PART A: TO BE COMPLETED BY APPLICANT

The information obtained in this certification process will only be used by the MVRTA for the provision of ADA and Non-ADA paratransit services. This information will be kept strictly confidential and will not be provided to any other person or agency (except to the ADA Appeal Officer, should you appeal your eligibility determination).

NOTE: PLEASE ANSWER ALL QUESTIONS.
INCOMPLETE APPLICATIONS CANNOT BE PROCESSED.

Client Information:

❑ New Applicant ❑ Upgrade Applicant ❑ 3yr Recertification ❑ Random Recertification

Last name:_____First:_____

Middle:_____Social Security #:_____

Age:_____Date of Birth:_____ Circle one: Male / Female

Home Phone:_____Work Phone:_____
(Please list at least one phone number to reach the applicant)

Street Address:_____Apt. #_____Bldg. #:_____

City:_____State:_____Zip code:_____

Mailing address if different from above:

Street Address:_____Apt. #:_____Bldg.#:_____

City:_____State:_____Zip code: _____

Person or agency to contact in case of an emergency:

Name:_____Relationship: _____

Street:_____Apt. #:_____Bldg.#:_____

City:_____State:_____Zip code: _____

Home Phone:_____Work Phone:_____

Do you already have an EZ Trans Card? ❑ Yes ❑ No If yes, ID#: _____

Do you use a Mobility Aid? ❑ Yes ❑ No If yes, what? _____

*Please include on a separate sheet of paper any other important contacts or information.

PART B: APPLYING FOR ADA CERTIFICATION

Please fill in all questions completely (if any question does not apply to you, please put N/A). **Any questions that are not filled in will result in an incomplete application and it will be returned to you, which will delay the processing of your application.**

1. What are all of your current means of transportation? Please check all that apply.

   ❑ Walking
   ❑ Mobility aids or equipment
   ❑ Public transit Bus
   ❑ Paratransit Van
   ❑ Automobile
   ❑ Taxi/car service
   ❑ Commuter railroad
   ❑ Medicaid transportation
   ❑ Other (specify): _____

2. Are you a holder of a statewide Access Pass (a picture ID that allows you to use public transportation at a discounted rate)? ❑ Yes ❑ No

3. Which of the following mobility aids or equipment do you use to help you get to where you need to go? Please check all that apply.

   ❑ Manual wheelchair
   ❑ Power wheelchair
   ❑ Power scooter
   ❑ Walker
   ❑ Cane
   ❑ Crutches
   ❑ Prosthetic device/brace
   ❑ Respirator/Oxygen tanks
   ❑ Guide cane
   ❑ Service animal (guide dog, etc…)
   ❑ I do not use a mobility aid
   ❑ Other (specify):_____

4. Using a mobility aid, equipment or standing on your own, what is the longest length of time that you can wait for transportation?

   ❑ 1-15 minutes
   ❑ 15-30 minutes
   ❑ 30-45 minutes
   ❑ 45-60 minutes
   ❑ Over 60 minutes
   ❑ I cannot wait without assistance

5. Using a mobility aid, equipment or walking on your own, how many blocks can you travel on level ground?
   Circle the answer below that best describe your situation

1 – 2 blocks	Never	Sometimes	Always
2 – 4 blocks	Never	Sometimes	Always
4 – 6 blocks	Never	Sometimes	Always
6 – 8 blocks	Never	Sometimes	Always
Over 8 blocks	Never	Sometimes	Always

6. How far is the closest MVRTA fixed bus route to your home?

❑ 0 – 1 block
❑ 2 – 4 blocks
❑ 4 – 6 blocks
❑ 6 – 8 blocks
❑ Over 8 blocks
❑ Don't know

7. Do you currently use the MVRTA fixed route bus system? ❑ Yes ❑ No

- If yes, how many days in one week _____
- If no, Please check all that apply:

❑ I get too confused and might get lost.
❑ I cannot walk that far.
❑ I do not want to ride on the fixed route bus system.
❑ The trip would involve too many transfers.
❑ There are no curb cuts, paved sidewalks or the ground is too uneven.
❑ I do not want to use a lift.
❑ My mobility aid will not fit on a lift
(Such a device that does not exceed 30" in width and 48" in length, measured 2" above the ground, and does not weigh more than 600 pounds when occupied).
❑ I do not feel secure on a lift.
❑ I cannot steady myself while the lift is moving.
❑ Other (please describe): _____

8. Can you reach your destination from where the fixed route bus stops to let you off? ❑ Yes ❑ No

- If no, Please check all that apply:

❑ I cannot walk that far.
❑ I become confused or cannot remember where I am going.
❑ I do not want to ride the fixed route bus system.
❑ There are no curb cuts, paved sidewalks or the ground is too uneven.
❑ Other (please specify): _____

9. If you do not ride the fixed route bus system, what would help you?

- Please check all that apply:

❑ Lift accessible buses.
❑ Knowing more about the fixed route bus system.
❑ I would travel if there were accessible fixed bus routes where I need to go.
❑ Other (please specify): _____

10. Please list the last two trips that you made and how you got there:

- Origin: _____ Destination: _____
Transportation used: _____

- Origin: _____ Destination: _____
Transportation used: _____

11. Can you follow written or oral instructions to use the fixed route bus system?
❑ Yes ❑ No

12. Do you need transportation at least three times each week for a regularly scheduled trip to a particular destination? ❑ Yes ❑ No

- If yes, please check all that apply:

❑ Dialysis treatment
❑ Therapy
❑ School
❑ Volunteer work
❑ Work
❑ Adult day program
❑ Senior Center
❑ Other:_____

13. Can you transfer from one regular fixed bus route to another?
❑ Yes ❑ No

- If no, please check all that apply:

❑ I get too confused and might become lost
❑ I do not like to transfer
❑ I cannot hold a paper transfer
❑ I do not want to use the fixed route bus system.
❑ Other _____

14. Can you climb three 12-inch steps without assistance? ❑ Yes ❑ No

- If no, please explain: _____

15. Can you communicate with the bus driver by yourself? ❑ Yes ❑ No

- If no, please check all that apply to you:

❑ I cannot understand the driver
❑ Other people cannot understand me
❑ I need a communication aid and do not have one
❑ Other (please specify): _____

16. Do you travel with a Personal Care Attendant (PCA, e.g., a person such as a home attendant or friend who assists you when you travel outside your home)?
❑ Yes ❑ No

- If yes, please check all that apply to you:

❑ Personal Care Attendant (PCA) helps me get to or from a bus stop
❑ Personal Care Attendant (PCA) helps me get on or off the bus
❑ Personal Care Attendant (PCA) helps me while I ride the bus
❑ Other (please specify): _____

17. Is your disability temporary? ❑ Yes ❑ No

- If yes, please indicate how long you believe the temporary disability will continue:

❑ 1 month
❑ 2 months
❑ Other _____ months (how many months?)

18. Is your condition affected by the weather? ❑ Yes ❑ No

- If yes, please explain: _____
  _____

19. Is your disability permanent? ❑ Yes ❑ No

20. What kind of place do you live in? Please check one.

❑ House ❑ Group Home ❑ Rehab Hospital
❑ Apartment ❑ Assisted Living ❑ Other: _____

21. Do you live alone? ❑ Yes ❑ No

22. How often do you do the following activities? (Check one for **each** activity.)

Activity	Every Day	Once a Week	Once a Month	Need Help? Y/N
Go to a restaurant				
Go shopping				
Go to meetings				
Go to the Post Office				
Go to the Doctor				
Go to Dialysis				
Visit Friends				
Visit Relatives				
Go to a movie				
Go to Bingo				
Go to Church				
Go to the Pharmacy				
Go to the Library				
Go to the Courthouse				
Go to the Bank				
Go to the Hairdresser				
Go to Therapy				
Go to Counseling				
Go to the Eye Doctor				
Go to a Nursing Home				
Go to Work				
Go to College				
Go to Housing				
Go to Welfare				
Go to Adult Daycare				

PART C: APPLICANT AGREEMENT AND INFORMATION

If you are not the applicant, but you completed this application on behalf of the applicant, you must provide the following information (please print or type):
Applicant's Name: _____
Name of person filling out this application: _____
Relationship to applicant: _____ Phone number: _____
Office Street Address: _____
City_____ State_____ Zip_____

I certify that the information given in this application is correct.

Signature: _____ Date: _____

AGREEMENT TO ELIGIBILITY TERMS AND CONDITIONS
(All applicants must sign this agreement.)

I understand that my application will be returned if it is incomplete and this will delay the processing of my application. I affirm that all information that I provide on this application is true to the best of my knowledge. I understand that my application is subject to review and verification and that misrepresentation of any material information will lead to revocation of my registration. I also understand that failure to adhere to the policies and procedures for using the EZ-Trans Services will be grounds for suspending my eligibility in this program.

X _____ _____
Applicants Signature **Date**

AMERICANS WITH DISABILITIES (ADA) APPEAL PROCESS

If your ADA paratransit eligibility determination results in a finding of ineligible to receive paratransit service or in a determination of limited or conditional eligibility and you feel that this determination has been made in error, you have the right to appeal this determination.

To file this appeal you must notify the MVRTA in writing within 60 days of the date on the determination letter. After your appeal is received, a hearing will be scheduled to evaluate your case. An independent source will serve as the appeal officer. The hearing process (which should not take more than 30 days) will allow you to present information and arguments on your behalf. You may have others present who are knowledgeable of your physical or mental impairment and who can speak on your behalf, but you must pay the cost for these other spokespersons. After the hearing, you will be advised in writing of the decision of the appeal board. The decision of the appeal board is final.

The MVRTA is not required to provide you with paratransit service while your appeal is under consideration. If the appeal board has not made its decision within 30 days of receiving your appeal, you are entitled to paratransit service from that time until a final decision is made.

PART D. REQUEST FOR PROFESSIONAL VERIFICATION

Dear Health Care Professional:

You are being asked to complete an assessment of the applicant's disability that prevents his/her ability to use the MVRTA fixed route bus system. By completing and signing this document you (the health care professional) will be certifying the truth and accuracy of the information provided on this application, to the best of your professional knowledge.

The Merrimack Valley Regional Transit Authority's (MVRTA) paratransit program, EZ Trans is partially funded through the Federal government. Federal law *(The Americans with Disabilities Act of 1990)* requires that the MVRTA provide services to persons who cannot use our fixed route bus system. However, resources for EZ Trans services are limited. The information you provide will allow the MVRTA to make an appropriate evaluation of this request for EZ Trans service. To qualify for EZ Trans service, a person must be unable to use fixed route bus system and fulfill the following eligibility criteria:

Individuals qualify if:

- As a result of their disability, they cannot board, ride, or disembark from a MVRTA fixed route bus; or

- They have a specific impairment related condition that prevents them from getting to or from a fixed bus route.

Please note:

- EZ Trans is a transportation service for disabled persons who, as a result of their disability, cannot board, ride or deboard from a MVRTA fixed route bus. ***(All MVRTA fixed route buses are handicap accessible)***

- EZ Trans service does not include persons who find it uncomfortable or difficult to get to and from fixed route buses.

- Your verification should consider only the presence of a disabling condition, not the applicant's age or economic status.

- The application must be filled out completely for processing to occur. **If the application is not complete it will be returned for completion, this will delay the processing of the application.**

Your evaluation of each person must be based solely upon the individual's ability to use the MVRTA fixed route bus system. Please exercise care in evaluating applicants for this program. ***False information used to acquire service for this applicant could result in travel limitations for other persons legitimately qualified to use this program.***

The following information will be used to ensure the appropriate type of vehicle is used to provide transportation.

1. Does the applicant use any mobility aids? ❑ Yes ❑ No

   If yes, what type?

   ❑ Manual wheelchair
   ❑ Walker
   ❑ Power wheelchair
   ❑ Power scooter
   ❑ Crutches
   ❑ Respirator/Oxygen tank
   ❑ Service animal (guide dog, etc…)
   ❑ Cane
   ❑ Guide cane
   ❑ Other: _____
   _____
   _____

2. Can the applicant transfer from a wheelchair/other mobility aid to a passenger seat if necessary? ❑ Yes ❑ No

3. Due to the applicants disability could the applicant be left unattended at a pick-up or drop-off location? ❑ Yes ❑ No

4. Please place a check next to yes or no to indicate whether the applicant can do any of the following:

   - Travel 2 blocks without assistance ❑ Yes ❑ No
   - Climb three 12-inch steps without assistance ❑ Yes ❑ No
   - Wait outside without support for 30 minutes ❑ Yes ❑ No
   - Give an address and phone numbers upon request ❑ Yes ❑ No
   - Recognize a destination or landmark ❑ Yes ❑ No
   - Deal with unexpected situations or changes in routine ❑ Yes ❑ No
   - Ask for, understand, and follow directions ❑ Yes ❑ No
   - Travel effectively through crowded/ complex facilities ❑ Yes ❑ No

5. Please <u>check all</u> of the disabilities, which would impair the applicant's ability to travel on the fixed route buses:

   Neuromuscular:

   ❑ Cerebral Palsy
   ❑ Muscular Dystrophy
   ❑ Parkinson's disease
   ❑ Arthritis
   ❑ Stroke/Cerebral Trauma
   ❑ Quadriplegia
   ❑ Multiple Sclerosis
   ❑ Paraplegia
   ❑ Other: _____

   General Medical:

   ❑ AIDS
   ❑ Diabetes (severe)
   ❑ Lupus
   ❑ Cancer
   ❑ Epilepsy (severe)
   ❑ Kidney disease/ Dialysis
   ❑ Other: _____

Cardiovascular:

- ❑ Arteriosclerosis
- ❑ Cystic Fibrosis
- ❑ Emphysema
- ❑ Congestive Heart Failure
- ❑ Chronic Obstructive Pulmonary disease
- ❑ Peripheral Vascular disease
- ❑ Thrombosis (chronic)
- ❑ Asthma
- ❑ Heart Attack
- ❑ Other: _____

Cognitive/Psychological:

- ❑ Alzheimer's disease
- ❑ Dementia
- ❑ Mental Retardation
- ❑ Phobia
- ❑ Autism
- ❑ Head Trauma
- ❑ Panic disorder
- ❑ Schizophrenia
- ❑ Other: _____

HEARING Check all that apply	One ear	Both ears
❑ Partially Deaf		
❑ Completely Deaf		
VISION Check all that apply	One eye	Both eyes
❑ Cataracts		
❑ Cortical Blindness		
❑ Glaucoma (all types)		
❑ Macular Degeneration		
❑ Retinal Detachment		
❑ Retinopathy		
❑ Legally Blind		
❑ Totally Blind		
❑Other:		

6. Please provide (type or print) a narrative assessment of the applicant's functional level of mobility.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

7. Would the applicant's condition prevent him/her from using the public fixed route service? ❑ Yes ❑ No

   - If yes, explain in detail: _____

   _____
   _____
   _____
   _____
   _____
   _____

8. Is the applicant's condition temporary? ❑ Yes ❑ No

   - If yes, expected duration is _____ months.
   - If yes, explain: _____

   _____

9. Would the applicant be conditionally eligible for EZ Trans service, due to weather conditions? ❑ Yes ❑ No

   - If yes, during which months would they need service: _____
   - If yes, explain:_____

   _____

10. In your assessment, would you require this person to ride with a PCA? Reasons to require a PCA could be any that would cause service disruptions.
    ❑ Yes ❑ No

    If yes, explain: _____
    _____
    _____

X _____ _____
Health Care Professionals Signature Daytime phone number

_____ _____
Health Care Professional Name (please print) Date

The MVRTA may contact the certifying Health Care Professional to verify accuracy of the information. The MVRTA will make the final determination as to the applicant's eligibility.

Thank you for your assistance.